STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155352	A. BUILDING _____ B. WING _____	C 02/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKHART REHABILITATION CENTER	2600 MOREHOUSE AVE ELKHART, IN 46517

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the investigation of Complaint IN00123548. This visit was in conjunction with the Recertification and State Licensure survey. Complaint IN00123548 - Substantiated. No deficiencies were cited. Survey Dates: February 4, 5, 6, 7, and 8, 2013 Facility Number: 000243 Provider: 155352 AIM Number: 100289830 Survey Team: Debora Kammeyer, RN-TC (2/4, 2/5, 2/6, 2/7, 2/8, 2013) Shawn Carson, RN (2/5, 2/6, 2/7, 2/8, 2013) Shelly Miller-Vice, RN (2/4) Lora Swanson, RN (2/4, 2/5, 2/6, 2/7, 2/8, 2013) Cenus Bed Type: SNF/NF: 52 Total : 52 Cenus Payor Type: Medicare: 3 Medicaid: 46 Other: 3 Total: 52 Sample: 3	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155352	A. BUILDING _____ B. WING _____	C 02/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKHART REHABILITATION CENTER	**2600 MOREHOUSE AVE ELKHART, IN 46517**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Quality Review completed on 2/18/13, by Brenda Meredith, R.N.	F 000		